

**Region 7**  
**Morris Hospital & Healthcare Centers**  
**ECRN Program**

Clinical Field Experience / Ambulance Ride-Time  
Preceptor Verification Report Form

(8 Hours for New Candidates)

ECRN-Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Date of Ride Time: \_\_\_\_/\_\_\_\_/\_\_\_\_

Ride Time Agency/Department: \_\_\_\_\_

Time In: \_\_\_\_\_:\_\_\_\_\_ Time Out: \_\_\_\_\_:\_\_\_\_\_ Total Hrs. \_\_\_\_\_

Number of ALS Runs: \_\_\_\_\_ Number of BLS Runs: \_\_\_\_\_ Total Runs: \_\_\_\_\_

Name of Paramedic in Charge (PIC): \_\_\_\_\_

Additional Crew Member: \_\_\_\_\_

Description of field call: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signature of PIC: \_\_\_\_\_ System #: \_\_\_\_\_

ECRN Candidate Signature: \_\_\_\_\_

**Once you complete your Ride Time hours, return this form and  
your Telemetry logs completely filled out to the Morris Hospital  
EMS System Office for submission to IDPH**